



DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 WORTH ROAD
FORT SAM HOUSTON, TX 78234-6000

REPLY TO
ATTENTION OF

OTSG/MEDCOM Policy Memo 07-052
19 DEC 2007

MCHO-CL-P

Expires 19 December 2009

MEMORANDUM FOR Commanders, MEDCOM Regional Medical Commands

SUBJECT: Coding and Billing Compliance Policy

1. References:

a. American Health Information Management Association (AHIMA) Standards of Ethical Coding, 1999, <http://www.ahima.org/infocenter/guidelines/standards.asp>.

b. AHIMA Coding Policy and Strategy Committee, "Practice Brief: Data Quality," Journal of AHIMA 67, No. 2, 1996.

c. Bowman, Sue. Health Information Management Compliance: Guidelines for Preventing Fraud and Abuse, Fourth Edition, AHIMA, 2007.

d. Office of Inspector General, Department of Health and Human Services, Compliance Program Guidance for Hospitals, 1998, <http://oig.hhs.gov/authorities/docs/cpghosp.pdf>, and OIG Supplemental Compliance Program Guidance for Hospitals, 2005, <http://oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>.

2. Purpose. To provide policy and procedures for ensuring uniform and compliant coding and billing practices, and provide procedures to address coding and billing compliance issues, including management of claims denied due to coding.

3. Proponent. The proponent for this policy is the Patient Administration Systems and Biostatistics Activity (PASBA), Ft Sam Houston, TX.

4. Policy. With transition from all-inclusive to outpatient itemized billing, effective 1 Oct 02, coding of outpatient services directly impacts billing. Since we use Diagnosis Related Groups for billing inpatient services, inpatient coding also directly impacts billing. It is, critical that our coding practices adhere to the official guidelines for coding and reporting, including the International Classification of Diseases, 9th Revision, Clinical Modification and Current Procedural Terminology/Healthcare Common Procedure Coding System. The imperative is to ensure appropriate reimbursement while also complying with coding guidelines.

*This policy supersedes the OTSG/MEDCOM Policy Memo, 9 Apr 03, subject: Coding and Billing Compliance Policy

MCHO-CL-P

SUBJECT: Coding and Billing Compliance Policy

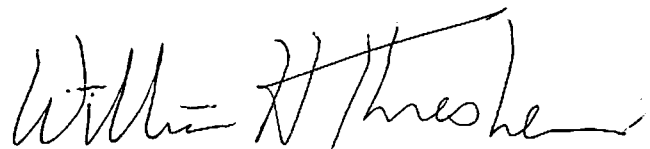
5. Responsibilities. MTF Commanders will develop and implement a coding compliance plan. The coding compliance plan will include procedures to address issues and corrective actions identified in this policy and will complement the MTF Uniform Business Office (UBO) compliance plan. Additionally, the procedures and corrective actions identified in this policy, as they apply to billing, will be incorporated into the MTF UBO Compliance Plan. All coding and billing personnel require familiarization with these issues and procedures for taking corrective action.

6. Procedures. To assist you in meeting these requirements, the following guidance documents are enclosed.

- a. Background - Coding and Billing Compliance Issues (enclosure 1).
- b. Guidance - How to Manage Claims Denied Due to Coding (enclosure 2).
- c. Sample Letter of Appeal for Claims Denied Due to Coding (enclosure 3).
- d. Sample Spreadsheet for Tracking Claims Forwarded for Coding Review (enclosure 4).

7. Our points of contact are coding—Mr. Royce Staley, PASBA, DSN 471-0471 or commercial (210) 221-0471; and for billing—Mr. Doug Ashby, Patient Administration Division, Office of the Assistant Chief of Staff for Health Policy and Services, DSN 471-7840 or commercial (210) 221-7840.

FOR THE COMMANDER:



WILLIAM H. THRESHER
Chief of Staff

4 Encls

1. Compliance Issues
2. Claims Guidance
3. Letter of Appeal Sample
4. Spreadsheet Sample

Background – Coding and Billing Compliance Issues

1. The collection of accurate and complete coded data is critical to healthcare delivery, research and analysis, reimbursement, and policy-making. The integrity of coded data and the ability to convert it into functional information requires that all users consistently apply the same official coding rules, conventions, guidelines, and definitions (the basis of coding standards). Use of uniform coding standards reduces administrative costs, enhances data quality and integrity, and improves decision-making.

2. Today, many coding practices are driven by health plan or payer reimbursement contracts or policies requiring providers to add, modify, or omit selected medical codes to reflect the plan or policies. Code sets are not revised on the same date, and often payors require the continued use of deleted or invalid codes. These variable requirements, which affect all medical code sets currently required for claims submission to third party payers, impact the integrity and comparability of healthcare data.

3. The American Health Information Management Association (AHIMA) Standards of Ethical Coding state that:

“Coding professionals should not change codes or the narratives of codes on the billing abstract. When individual payer policies conflict with official coding rules and guidelines, obtain the payer policies in writing. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer’s policy.”

4. The AHIMA clearly states that it is the medical facility’s responsibility to confront payers when denials in claims are due to a conflict between a payer requirement and the official coding rules or guidelines. Coding and billing staff are responsible for contacting that payer, explaining the irregularity, and indicating that the conflict could cause data inconsistency and comparability problems reference the applicable coding guidelines in discussions, and included with any documentation sent to the payer for resolving the conflict.

5. The AHIMA Payer’s Guide to Healthcare Diagnostic and Procedural Data Quality, 2001 edition, available at www.ahima.org, is a useful tool to support the MTF’s position and the underlying rationale.

6. The Health Insurance Portability and Accountability Act (HIPAA) requires the adoption of standards for code sets for data elements that are part of all healthcare transactions. The regulation pertaining to electronic transactions and code sets promulgated under the HIPAA includes the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology/HCFA Common Procedure Coding System. Under the HIPAA, both payers and providers are required to adhere to the official ICD-9-CM Guidelines for Coding and Reporting. The

MTFs should stress the importance of adhering to these guidelines with their payers so that MTFs will receive appropriate reimbursement for the item or service without being required to violate coding rules and guidelines.

7. The MTF UBO staff should investigate all discrepancies between payer policies and official guidelines. The MTF UBO staff should also appeal all full and partial payment denials they believe to be invalid. Finally, the MTF UBO staff should monitor claims denials for patterns of errors and take corrective action when they identify a pattern. For additional guidance on managing claims denials and submitting appeals, see enclosures 2 and 3.

Guidance – How to Manage Claims Denied Due to Coding

1. Scenario: Insurance carrier partially or fully denies payment on a claim, indicating that coding was invalid or does not meet their requirements.

2. Investigation:

a. Billing Supervisor: will ensure that the billing office personnel do not change coding to accommodate the payer's requirements. Rather, take the following actions:

(1). Pull claim data to identify the codes used for billing.

a. Contact insurance carrier or visit them in person, if possible, to identify why the claim was denied and what CPT (or other) code they are looking for on the claim. If possible, obtain in writing the reason for claim denial and the specific CPT or other codes they want on the claim in lieu of those used, and why. If successful in getting the insurance carrier to reconsider the claim, resubmit the claim. If unsuccessful, continue with step b.

b. If the code is for a service not covered by the plan, obtain proof, attach it to the claim file with the Explanation of Benefits (EOB), and close the claim with the appropriate transaction code.

c. If the code used is not recognized by the plan's system, request for explanation in writing why, and for the code that is recognized in that particular situation. Attach this explanation to claim file with the EOB and provide to coding auditor or coding supervisor for review.

(1) Attach to claim file a coding review request and provide a copy of the complete claim file to the billing supervisor for coordination with the coding supervisor or coding auditor.

(2) Establish a spreadsheet to track and trend claim review requests and outcome. A sample spreadsheet is provided as enclosure 4.

2. Document the name of the individual, the telephone number, date, time, and the content of your discussion with the insurance carrier representative.

3. Obtain the mailing address to send an appeal and a telephone number to contact related to appeals. If available, obtain the name of an individual to contact regarding appeals.

4. Take all information gained to the billing supervisor for coordination with the coding supervisor or coding auditor.

5. Billing supervisor coordinate with the coding auditor or supervisor, to discuss the claim denial and to ask them to review the coding to verify it is correct.

6. Track and trend denials by payer for reasons associated with coding.

B. Coding Auditor or Coding Supervisor.

1. Pull the medical documentation for the claim.

2. Review the coding on the claim.

a. If the coding is correct:

(1) Make a copy of the applicable coding guidelines.

(2) Provide to billing supervisor a written summary of why the coding on the claim is correct, and cannot be changed to meet the insurance carrier's requirements, attach the coding guidelines.

(3) Billing supervisor submits appeal to insurance carrier, attach written justification of why coding is correct (paragraph III).

b. If the coding is not correct, coordinate with billing supervisor to revise the coding on the claim for resubmission by billing. Correct all coding documentation to correspond with the revised coding on the claim.

III. Appeal Letter – Billing prepare a letter of appeal (sample letter, enclosure 3).

A. First paragraph outlines the reason you are writing your letter.

B. Tell your story – reconsideration of the claim for payment and actions previously taken (indicating dates and with whom you spoke) with payer in an attempt to resolve.

C. State your request and ask if additional information is needed.

D. Indicate how the insurance carrier can contact you.

E. Close the letter.

Sample Letter of Appeal

UBO Rep & Phone #
Mailing Address
City, State Zip Code

Current Date

Name of Insurance Carrier
Contact
Mailing Address
City, State Zip Code

Re: Patient Name, Insurance Carrier Identification Number, Insurance
Carrier Group Number (if necessary), Date of Service, Claim Number

Dear XXXXX (To Whom It May Concern),

You have apparently denied/reduced payment of the above referenced claim(s) because (MTF Name) submitted an invalid (ICD-9-CM/CPT/HCPCS) code. We disagree with your determination.

Upon investigation of this denial, we have identified that the coding on this service (indicate code used) is correct under the current coding guidelines, which are attached for your review.

(Name of the MTF) makes every effort to ensure that claims are submitted with accurate coding. Request you consider the attached information and reprocess this claim for payment. If you require additional clinical documentation to support the services provided, please submit your request in writing to: Name MTF, Mailing Address, City, State, and Zip Code.

Thank you in advance for your time and consideration of this request. If I can provide you with additional detail, feel free to contact me at the above noted telephone number.

Sincerely,

Signature
NAME
Title

2 Encls

1. Coding Guidelines
2. Additional Information

Enclosure 3

Sample Spreadsheet for Tracking Claims Forwarded for Coding Review

DOS	MEPRS	Type of Bill	Code Denied	Description of Code	Reason	Ins Co.	Date to Coding for Review	Coding Review Outcome	UBO Action	Date of Action	Results
03/03/07	BGAA	Lab/Rad	V78.9	Unspecified disorder of blood and blood-forming organs	Because these charges are for services that are not related to a specific medical condition, the plan is unable to pay these charges	MHBP	04/03/07	Dx Code Corrected	Resubmitted	05/03/07	Paid OON
03/03/07	BGAA	Clinic	V72.31	Routine cervical papanicolaou smear that is part of a general gynecological exam	NC due to only pays for one per year.	BCBS	04/03/07	Dx Code Corrected	Resubmitted	05/03/07	Paid INN
03/03/07	BBAA	Lab/Rad	V72.0	Examination of eyes and vision	This charge is NC by the members plan	UHC	04/03/07	Dx Code Corrected	Resubmitted	05/03/07	Paid INN
03/03/07	BGAA	Clinic	99212	Office viist	Not covered at same visit	Aetna	04/03/07	Moved modifier - 25 from 99396 to 99212	Resubmitted	05/03/07	Paid INN
03/03/07	BAPA	Clinic	70.09	Oth Dyschromia	The procedure/Dx code submitted is invalid because it does not exist.	APWU	04/03/07	Dx Code Corrected	Resubmitted	05/03/07	Paid PPO
03/03/07	BIAA	ER	682.5	Cellulitis of buttock	Non emergent ER is NC	GEHA	04/03/07	Dx Code Corrected	Resubmitted	05/03/07	Paid OON
03/03/07	BAAA	Clinic	780.99	Other General Symptoms	Dx code is too generic	Cigna	04/03/07	Dx Code Corrected	Resubmitted	05/03/07	Paid INN